PAIN MANAGEMENT

If you have questions regarding Pain Management, you may call Dr. Thiru Anaswamy, MD, MA, Physical Medicine and Rehabilitation Service at 214-857- 0273 or you may send him an e-mail message through Veterans Health Information Systems and Technology Architecture (VISTA) or Microsoft (MS) Exchange (Outlook).

1. Short-acting analgesic medications may be helpful for patients with chronic pain. If a patient's pain control is sub-optimal with frequent doses of short-acting pain medications every day, it is appropriate for the physician to consider the addition of a "long-acting" medication for improved pain control.

2. Significant progress has been made over the last 30 years in diagnosing and managing patients with chronic pain. The vast majority of patients will benefit from these advances. Treatment methods cover the whole spectrum from physical and occupational therapy to medication and psychological counseling to interventional pain management procedures and surgical operations.

3. The risk of addiction to opioid (narcotic) pain medication is a common fear among patients with chronic pain. Addiction is defined as psychological dependence and continued use of medication despite harm (e.g. overdose). Addicted persons lose control over the medication and make great efforts to obtain as much medication as possible. Addiction is a multifactorial phenomenon with a genetic component. Patients without a mental history of addictive illness who have chronic pain and use the medication as prescribed very rarely get addicted.

4. Patients with previous and/or ongoing episodes of illicit drug use are at much higher risk to become addicted when they are given opioids. To minimize this risk it is recommended to obtain an Opioid Agreement, do frequent drug screens to recognize a relapse and to prescribe medication with slightly less abuse and addiction potential. Short-acting opioids like hydrocodone have a high abuse potential while slow-onset long-acting opioids (like methadone) are less often abused. Patients with ongoing illicit drug abuse should be referred to Mental Health for Substance Abuse counseling before any opioids are considered.

5. Patients who take opioids for over 2 weeks will usually experience withdrawal (increased pain, sweating, chills, anxiety), when the medication is discontinued abruptly. This physiological dependence must not be confused with psychological addiction. It is comparable to the rebound phenomena that happens after abrupt discontinuation of beta-blockers or clonidine. It is important to make the distinction between physiological dependence and psychological addiction clear to the patient and the family.

6. The VA North Texas Healthcare System (VANTHCS) offers, through its multiple specialty clinics, expertise and facilities to treat patients with chronic pain. A lot of information about these clinics and what service they offer can be found in the Pain Management Policy (CP-1 0), which is posted on the VA Intranet under the section: VANTHCS Policies.

7. Interventional pain management, which is the utilization of injections and “blocks” for the treatment of pain, can often result in better pain control and improved functioning. These procedures are performed at the VA North Texas Health Care System (VANTHCS) by physicians with special training and expertise in pain management following the same standards as respective physicians outside the VANTHCS.

8. The goal of multidisciplinary pain management is to leverage the expertise and experience from different departments to improve the patient’s pain and function using an integrated and collaborative approach. This includes addressing the physical, mental health and spiritual needs of the patients. Multidisciplinary approach to pain management often results in better outcomes.

9. Pain is very common in cancer (especially late in the disease process) and has to be addressed aggressively. The majority of cancer patients can achieve adequate pain control and live with the use of opioids and adjuvant (supplemental) pain medications. A small minority of patients will need additional, more invasive procedures to decrease their pain and improve their functioning.

10. Many of the elderly attribute pain as part of the natural aging process and therefore tend not to report their pain. Unrelieved pain in the elderly leads to disturbed sleep patterns, fatigue, depression and functional impairment, which greatly affect their quality of life. Elderly patients in pain may avoid certain movements and may require assistance with Activities of Daily Living (ADLs).

11. Pain assessment is a subjective self-report requiring verbalization of pain; however, patients with dementia may be unable to self-report their pain. Therefore, it is important to be aware of possible objective indicators of pain including frowning, grimacing, tense body posturing, agitation, aggression, sadness, wandering, pacing, and noisy breathing.

12. Pain assessment in the elderly can be difficult or inaccurate because they may have sensory impairment, depression, or decreased cognitive functioning. Some elderly patients may describe their pain as discomfort, burning, soreness, heaviness, or aching, which can be misinterpreted by staff since they may not use the word "pain" as a descriptor. Therefore, it is important to use a variety of measures including verbal communication (pain descriptive scale), visual communication (visual analog scale), assessment of

behavior (faces scale) and the Non Verbal pain Scale (NVPS) to assess pain accurately in the elderly.

13. Chronic pain is frequently associated with fear of movement, reduced physical activity and deconditioning. On advice from a treating physician or care provider, patients with chronic pain may begin and maintain a regular, prescribed exercise program to counteract the ill effects of inactivity and deconditioning. This exercise program may need to be reviewed and revised periodically.

14. Heat, cold, and electric stimulation are commonly used to effectively reduce and manage pain. This type of stimulation is often prescribed and used by physical and occupational therapists. The VA North Texas Healthcare System (VANTHCS) physical and occupational therapy services are available through Physical Medicine & Rehabilitation Service (PM&RS). A consultation/referral to a therapist in PM&RS may be appropriate for a patient in pain.

15. Patients who receive long-acting medication for pain control should have a short acting medication available for “breakthrough” pain, when a long-acting drug fails to control their pain effectively.

16. There is no “ceiling” (maximum) dose for opioid medications, large doses may be given safely in a patient to maintain an acceptable level of pain control with attention to potential side effects.